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BY AAPC

Optometry Coding & Billing Alert

Reader Questions: Focus on Payer Rules Governing 51 Use

Question: I have heard our coders saying that they don't need to attach modifier 51 to claims. I am confused as to why there would be a modifier if we don't need to use it. Can you explain?

Oklahoma Subscriber

Answer: Your coders are likely correct. Many payers, including Medicare, do not require practices to use modifier 51 (Multiple procedures) on claims.

Appending modifier 51 to the second or third procedure tells the payer that you did multiple procedures in the same operative session. One way you can look at modifier 51 is to think of it as an informational-type modifier for use on the second, third, etc., surgical procedure performed on the same day. But some payers do not want you to use this modifier at all.

Here's why: Processing claims electronically allows the payer to recognize when your physician performs multiple procedures and automatically make the necessary reduction in payment. The insurer's software automatically sorts the procedures on your claim in order from highest to lowest relative value units (RVUs). The payer then pays the highest-ranked procedure at 100 percent and any additional surgical procedures at 50 percent.

However, some smaller payers may require the use of this modifier. Before you submit your claim, you should contact your insurance carrier and ask which method it would prefer when reporting multiple surgical procedures.

Payer example: On Feb. 6, NGS Medicare issued new policy education for modifier 51 explaining that it "denotes more than one medical/surgical procedure is being performed by the same physician on the same day during the same encounter."

However, the MAC adds, "Medicare does not recommend reporting modifier 51 on your claim submission." The MACs' systems contain "hard-coded logic to add the 51 modifier to the correct procedure code," so you don't have to add it again, NGS says.

To read the complete guidance from NGS, visit www.ngsmedicare.com.